OneMain Solutions

Underwritten by: **American Health and Life Insurance Company**
1420-380 Wellington Street London, Ontario N6A 5B5
T 800-285-8623 | Fax 877-772-2623 | InsClaims@omf.com
www.americanhealthandlife.ca
Monday through Friday, 8:00 a.m. - 8:00 p.m., ET

Name _____ Account # _____ Claim # _____

Life Claim Form

NOTICE

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the applicable provincial legislation: In Alberta - *Insurance Act*; In British Columbia, New Brunswick, Nova Scotia, Prince Edward Island, Yukon, Northwest Territories and Nunavut - *Insurance Act*; In Manitoba - *The Insurance Act*; In Ontario - *Limitations Act of 2002*; In Saskatchewan and Newfoundland - *The Limitations Act*; In Quebec - *The Civil Code of Quebec*.

INSTRUCTIONS

1. **When all required sections are complete, return the form to the office listed above or upload your claim documents on our website, www.americanhealthandlife.ca .**

2. **Attach the following documents:**
   - ☐ **A copy of the Loan Protection Insurance Application.**
   - ☐ **A black and white copy of the transaction history showing last payment prior to date of death and all transactions since that date.**
   - ☐ **A black and white death claim payoff inquiry screen print as of the date of death.**
   - ☐ **If Section III is not completed, a copy of the certified Death Certificate, Coroner's report or funeral director's statement is required.**

3. **Keep a copy for your records. Please be aware email is not considered a secure method of delivery for personal/medical information.**

4. **If the insurance certificate contained a health question or statement, have the deceased's next-of-kin complete the Next-of-Kin Authorization.**

Note: Altered forms cannot be accepted.

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NEXT-OF-KIN AUTHORIZATION - To be completed by the deceased's next-of-kin, if the insurance certificate contained a health question or statement. Give the name(s), complete address(es) and telephone number(s) of any physician, hospital or other person who has attended the deceased insured and any pharmacy that filled a prescription for the deceased insured within the past 5 years.

NAME	FULL ADDRESS	TELEPHONE NUMBER

PERSONAL INFORMATION AUTHORIZATION

I have read and fully understand the contents of the Notice Regarding Collection, Use and Disclosure of Personal Information ("Notice") and acknowledge and consent to American Health and Life Insurance Company collection, use and disclosure of _____.'s personal information information for the purposes identified in the Notice. For the purposes of claim investigation and processing, I hereby authorize, consent, and direct any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, employer, any workers compensation board, Human Resources and Skills Development or any other organization, institution, association or person identified in the Notice that now has or may in future have any records or knowledge concerning _____. or _____.'s health, employment history, benefits paid or any related information to disclose to American Health and Life Insurance Company, their authorized representatives and reinsurers, upon the request of American Health and Life Insurance Company information any such information that is material to the purposes identified in the Notice. A photocopy of this authorization shall be as valid as the original.

Next of Kin Signature _____ **Date** (MM/DD/YY) M M / D D / Y Y

Relationship to Insured

Complete Mailing Address **City** **Prov.** **Postal Code**

EXPLID

10-14-21

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Name _____ Account # _____ Claim # _____

Life Claim Form - Statement of Attending Physician - To be Completed by Attending Physician

Completed without expense to the insurance company.

Date of death (MM/DD/YY) **Date of birth** (MM/DD/YY)

Place of death

Cause of death **(disease or condition directly leading to death)**

Death due to consequence of

Other significant conditions **(contributing to death, but not related to the disease or condition causing death)**

Death due to ☐**Natural** ☐**Accident** ☐**Suicide** ☐**Other (please explain)** _____

Have you advised, consulted or treated the deceased during the past 3 years? ☐**Yes** ☐**No**

Date deceased was informed of diagnosis (MM/DD/YY)

Family doctor's name

Complete mailing address **City** **Province** **Postal code**

Printed name of attending physician or coroner **Telephone #**

Complete mailing address **City** **Province** **Postal code**

Signature of attending physician or coroner **Date** (MM/DD/YY)